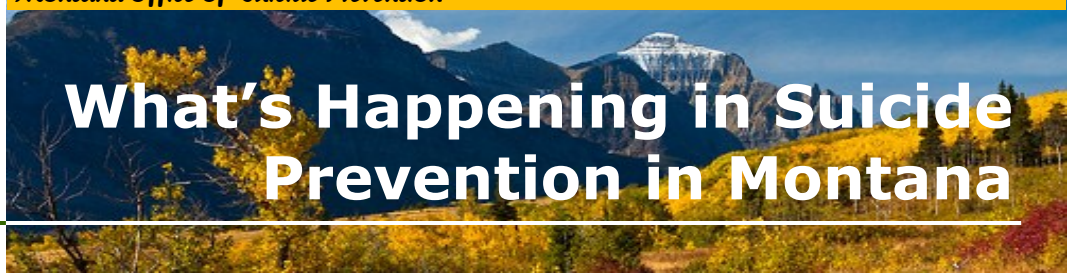
Montana Office of Suicide Prevention



What's Happening in Suicide Prevention in Montana

Fall, 2013

Wanting to keep you informed and collaborating to find a solution

As most of you know, Montana has one of the highest rates of suicide in the nation, and has for more than three decades. Suicide and the stigma against mental illness has been part of the Montana culture for a hundred years. This isn't going to change quickly. It is going to take a cultural shift in the way we think and an openness to talk about these issues. The purpose of this newsletter is to inform the public of ongoing prevention activities taking place in communities around the state, identifying community advocates, and encouraging input from all Montanans on how we can address the issue of suicide in our state.

Webinar focuses on providing resources to primary care providers working with Montana veterans.

On August 15, a webinar sponsored by the Montana Hospital Association, was held for hospitals and primary care providers around the state on suicide prevention in our veterans. The webinar was part of a series of events focusing on primary care providers role in caring for our veterans.

The webinar addressed the clinical practice guidelines outlined by the Veterans Administration and the Department of Defense for the assessment and management of patients at risk for suicide. Also covered were elements found in SAMHSA's Suicide Prevention Toolkit for Rural Primary Care Providers, which can be downloaded at no cost from www.prc.mt.gov/suicideprevention.

Webinar attendees were provided the VA/DoD Guidelines, SAMHSA's SAFE-T (Suicide Assessment Five-step Evaluation and Triage) handout, information promoting the Veterans Crisis Line, and office posters promoting "Suicide Spoken Here", which encourages patients to talk about issues of depression and suicide with their physicians.

The webinar was facilitated by Karl Rosston, LCSW, who is the Suicide Prevention Coordinator for the Montana Department of Public Health and Human Services. For information about any of these materials, contact Karl Rosston at krosston@mt.gov

New Video Provides Guidance to our Nation's Firefighters in Coping with Suicide

The Carson J Spencer Foundation, in partnership with the National Action Alliance for Suicide Prevention, and the American Association of Suicidology, launched a new video entitled *Firefighters Coping with the Aftermath of Suicide*, detailing self-care steps, peer support measures, suicide warning signs, and available resources to assist firefighters nationwide in coping with suicide.

"Fire service professionals can sometimes be overlooked when thinking about the impact of suicide. When a suicide occurs, their role often shifts from rescuer to fellow griever. This can sometimes be challenging for firefighters who may be unprepared for the intense, complicated, and lengthy trauma involved with suicide," said Sally Spencer-Thomas, CEO and Co-Founder of the Carson J Spencer Foundation and producer of the video.

The video features real firefighters, many from South Metro Fire Station 34 of Lone Tree, CO, who describe their struggles in coping with the difficulty of a suicide call or the suicide of a fellow firefighter and how vital it is for fire safety departments to work on raising awareness of this issue among firefighters, who are trained to face traumatic events but are sometimes unprepared for the unique trauma associated with suicide.

To watch *Firefighters Coping with the Aftermath of Suicide*, please visit http://www.youtube.com/watch?v=Ryy7EyAiyeQ.

Community: What can a Rural Montana Community do about Suicide Prevention?

For most people, living in Montana means living in a small rural community that is geographically isolated with limited public health services. This is an issue that is not going to change. However, it does not mean that communities are helpless to reduce the incidence of suicide. The following protocol are low or no cost interventions, most of which fall in line with 2012 National Strategy for Suicide Prevention (http://actionallianceforsuicideprevention.org/NSSP)

1. Identify the prevention advocates in your community
2. Have advocates attend a gatekeeper training (contact DPHHS Suicide Prevention Coordinator for trainings) and have at least one advocate take the online course to become a trainer . Two of the better known gatekeeper trainings are:
   - Question, Persuade, Refer (QPR) – http://www.qprinstitute.com/
   - SafeTALK - http://www.livingworks.net/
3. Provide schools with the SAMHSA toolkit, "Prevention Suicide: A Toolkit for High Schools". The toolkit can be downloaded for free at www.prc.mt.gov/suicideprevention
   - Have a QPR training for all staff.
   - Implement the SOS Signs of Suicide Prevention Program into your middle and high school, which is available at no cost through DPHHS. For more information about the SOS Program, visit http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/default.aspx
   - Introduce "The Good Behavior Game" into your K-6 schools. For more information, go to http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf. (contact the Suicide Prevention Coordinator for assistance)
4. Provide primary care providers with a "*Suicide Prevention Toolkit for Rural Primary Care Providers*" and the "*Depression Management Toolkit*". These toolkits can be downloaded for free at www.prc.mt.gov/suicideprevention. In addition, Primary Care Providers can be provided with the PHQ-9, which is a brief screening tool for depression. This can be found at http://www.depression-primarycare.org/images/pdf/phq_9_eng.pdf
   - Once the toolkits have been provided to primary care providers, advocate for them to do **universal** screening for depression with all of their patients or, at the very least, ask *all* patients, "have you had any recent depression or suicidal thoughts?".
5. Provide senior living facilities with a "*Suicide Prevention Toolkit for Senior Living Communities*". These toolkits can be downloaded for free at www.prc.mt.gov/suicideprevention.
6. Provide community trainings to those who have contact with high risk populations, (gun retailers, bartenders, cosmetologists, pharmacists, law enforcement, first responders, clergy). The trainings should focus on recognizing the warning signs, how to intervene, and community resources.
7. Develop a volunteer call-tree that identifies high risk people in the community and makes weekly 3-5 minute "check-in" phone calls to reduce social isolation.
8. In the absence of a nearby crisis stabilization program, identify advocates in the community who would be willing to stay with a person in crisis for up to 72 hours (could be a pool of people who take turns). If the person continues to be at high risk after 72 hours, contact a local primary care provider about the need for a possible involuntary commitment to the Montana State Hospital or other designated crisis stabilization hospitals.
9. Make sure that the number for the Montana Suicide Prevention Lifeline (800-273-8255) is well advertised throughout the community (Posters available through the DPHHS Suicide Prevention Coordinator)

Suicide Rates High Among the Elderly

TAKEN FROM THE NEW YORK TIMES, AUGUST 7, 2013 (http://newoldage.blogs.nytimes.com/2013/08/07/high-suicide-rates-among-the-elderly/?emc=eta1&_r=0)

In hindsight, Greacian Goeke can see that there were warnings.

Her father, Joseph, had never fully recovered from surgery to repair a heart valve and feared he would soon need a wheelchair, as his own father had. He had developed cataracts and had to stop driving. Along with his increasing physical disability, he had a history of depression that included hospitalizations and electroconvulsive therapy. For years, he had struggled with alcohol abuse.

Yet Ms. Goeke, who was starting graduate school across the country in California in 1986, was only vaguely conscious of those problems. "The culture in our home was not to talk about things in an up-front, personal way," she told me. "I didn't put it together."

So it came as an utter shock when her mother called from New Jersey to say that her father had killed himself, using an old shotgun intended to keep groundhogs from destroying his garden. Just 69, he had still been working part-time as an opinion research executive.

"I can't imagine wanting to do that," his daughter remembers shouting into the phone. "How could you hate life that much?"

For most people, psychological well-being increases later in life, following a well-known U-shaped curve: people report less satisfaction in midlife and more at either end of the age spectrum. Paradoxically, though, suicide rates also rise sharply. Older white men, like Joseph Goeke, are particularly at risk.

Among Americans of all ages, 12.4 per 100,000 take their own lives each year, according to 2010 statistics from the Centers for Disease Control and Prevention. But among those over 65, the official number is 14.9, and suicide may be under-reported. Because of the stigma, "coroners will go to great lengths to call it something else," said Patrick Arbore, founder and director of the Center for Elderly Suicide Prevention in San Francisco. "If it's an overdose, they can call it an accident."

Though suicides among older people have declined in recent decades, most likely as a result of improved screening and treatment for depression, they remain disturbingly high among men. Suicides by women decline after age 60, but the rate among men keeps climbing. Elderly white men have the highest rate: 29 per 100,000 over all, and more than 47 per 100,000 among those over age 85.

Why are suicide rates so high among seniors? We know that while older people make fewer suicide attempts than the young, they are far more likely to die from them, in part because they rely primarily on guns. "Younger people have more physical resilience and use less lethal means," said Dr. Yeates Conwell, a psychiatrist at the University of Rochester Medical Center who has studied late-life suicide.

Moreover, depression is behind a majority of suicide attempts, and "a lot of older people have problems asking for help," Mr. Arbore said. Depression can involve different symptoms in older patients, and "men are good at masking it, because we've been conditioned to believe it's not O.K. to express emotional pain."

Beyond mental illness, researchers have identified a cluster of other risk factors in late-life suicide, including physical illness and pain, the inability to function in daily life, fear of becoming a burden and social disconnection. "Things that remove older people from their social groups — bereavement, retirement, isolation — leave them vulnerable," Dr. Conwell said.

Knowing that some readers here have announced that they want to end their lives if (or before) they are suffering, seeing that as an exercise of personal autonomy rather than mental illness, I asked both experts if they thought suicide could ever be a rational act. If life loses pleasure and meaning, with or without a terminal disease, can suicide be a legitimate response?

Both said, cautiously, that in certain situations, after a great deal of discussion and consideration, it could be — but that's rarely what occurs.

"The proportion of older people who take their lives without a diagnosable mental illness is very, very small," Dr. Conwell said. Because elderly suicide is generally a result of multiple factors — physical illness and depression and a recent loss, say — "if you change one of those parameters, it may tip the balance in favor of finding solutions that help you want to live."

At the Center for Elderly Suicide Prevention, staff and volunteers handle 3,000 calls a month to the "friendship line" (a name deemed more acceptable to seniors than "suicide hotline"). They also place 3,500 outgoing calls to people considered isolated or otherwise at risk.

"We believe connections are what bind us to life," Mr. Arbore said. "Just having the opportunity to talk might shift their view of the end, temporarily. It might not have to happen today."

Such opportunities to talk, in ways tailored to older adults, should be more widely available than they are. (One resource is the Veterans Affairs Department's Veterans Crisis Line.) Instead, the task of trying to recognize elderly depression and encourage treatment falls largely to primary care physicians and, of course, to family members, who should always take suicidal talk seriously. When a depressed and hopeless relative commits suicide, the family must cope not only with grief but often with guilt and unanswered questions.

Karl Rosston, LCSW
Suicide Prevention Coordinator
Montana DPHHS
555 Fuller Ave.
Helena, MT 59620
(406) 444-3349
krosston@mt.gov

Are there suicide prevention activities going on in your community that you want to share? Please let us know and we will include it in this newsletter. Send your information to Karl Rosston at krosston@mt.gov.

Research: Biomarkers for Possible Blood Test to Predict Suicide Risk Identified

Web address: **http://www.sciencedaily.com/releases/2013/08/130820083759.htm**

Indiana University School of Medicine researchers have found a series of RNA biomarkers in blood that may help identify who is at risk for committing suicide.

In a study reported Aug. 20 in the advance online edition of the Nature Publishing Group journal *Molecular Psychiatry*, the researchers said the biomarkers were found at significantly higher levels in the blood of both bipolar disorder patients with thoughts of suicide as well in a group of people who had committed suicide.

Principal investigator Alexander B. Niculescu III, M.D., Ph.D., associate professor of psychiatry and medical neuroscience at the IU School of Medicine and attending psychiatrist and research and development investigator at the Richard L. Roudebush Veterans Affairs Medical Center in Indianapolis, said he believes the results provide a first "proof of principle" for a test that could provide an early warning of somebody being at higher risk for an impulsive suicide act.

Study: Mental illness, not combat, causes soldier suicides

http://www.cnn.com/2013/08/06/health/soldier-suicides-cause-study/index.html?hpt=hp_bn13

Need resources for your suicide prevention efforts? Start by visiting the Montana Suicide Prevention website for data, research articles, toolkits, handouts, and additional information. Go to www.prc.mt.gov/suicideprevention

(CNN) -- The record number of military suicides seen in recent years may not be directly due to extended deployments or combat experience, according to a new study. This data analysis, funded by the Department of Defense, suggests that the real reason behind the growing number of military suicides is underlying mental health issues in this population.

Their findings will be published in the next edition of the Journal of the American Medical Association.

What's causing soldiers to kill themselves at a record rate -- there were 325 confirmed or potential suicides last year among active and non-active military personnel -- are the same mental health problems that can be found in the general population, according to the study authors: depression, manic depression and alcohol abuse.

These are all problems that are fundamentally treatable at some level. But the military will have to change the way it handles soldiers with mental illness if we expect to see the number of suicides decline, according to the author of a related editorial published in the journal.